The core questionnaire aimed to obtain information about the demographics of the CBOs surveyed. It asked which populations they serve, where they provide services, the nature of those services, their size, and their board make-up. This data provides a profile of the sampled CBOs for better understanding the differences and commonalties among organizations providing HIV prevention. Further, this information gives a context for the TA/T needs captured in this report.

Target Populations and Distribution of CBOs

The sample of CBOs covered all 50 states and Puerto Rico. Figure 1 *(Appendix A, page 41)* shows the distribution, with the highest concentrations of CBOs in California, Arizona, and New York. Of the CBOs sampled, the largest percentage targets African-American populations (23.6%), followed by Hispanic/Latinos (18.2%) and Caucasians (17.8%) (*see Figure 2, Appendix A, page 42*). Native Hawaiian (0.7%) and Native Alaskan (1.1%) were the least-served populations. It is surprising that close to 20% of the sampled CBOs primarily target Caucasians because the sample was selected to reach CBOs serving minority populations. This may have been because, when selecting CBOs from the CDC National Prevention Information Network database, it was not specified that the CBO must *primarily target* racial/ethnic minority populations, but merely *serve* these populations. It would be worthwhile to follow-up on this information and ensure that the racial/ethnic minorities being served by these CBOs are receiving culturally competent HIV prevention services.

Size and Character of CBOs

Of the CBOs sampled, more than 50% have been providing HIV prevention programs for more than seven years (*see Figure 3, Appendix A, page 43*) and close to 75% have been providing programs for more than four years. Only 4.7% have been in existence for less than one year, possibly because newly formed CBOs may not yet be in contact with the CDC or NRMOs. CBOs targeting Native Americans tended to have provided HIV prevention for less than three years, 42.3% as compared to 21.2% in the overall sample. Further, CBOs that have been around for more than seven years were more likely to serve more than 2000 people than in the overall sample (75% versus 57.5%).

As described in Figure 4 *(Appendix A, page 44)*, the CBOs surveyed were almost equally distributed between providing services in inner-city, urban, rural, and rural and urban settings (19.1%, 20.7%, 18.2% and 25.8%, respectively). The areas that were not as frequently chosen as a primary service area were suburban (3.1%) and remote (3.3%).

A cross-tabulation between the prevention service areas and the primarily targeted population showed that CBOs serving African-Americans and Hispanics/Latinos have higher concentrations in inner-city areas (39.4% and 31.7%) than the overall sample inner-city rate of 20.1%. The CBOs targeting African-American populations were under-represented in rural areas (7.7% versus overall sample rate of 19.1%).

Sampled CBOs targeting Asians/Pacific Islanders have higher percentages in urban areas and lower percentages in rural areas than the overall sample (urban: 50% compared to 22.2% for the overall sample; rural: 2.0% compared to 19.1% for the overall sample).

CBOs that primarily target Caucasians tended to be in suburban (7.6% versus 3.3% for the overall sample) or rural areas (34.2% versus 19.1% for the overall sample). Native American CBOs also were concentrated in rural areas (35.6% versus 19.1% for the overall sample).

The CBOs who serve "no specific racial/ethnic populations" tended to characterize the areas they serve as rural and urban. This may be because these CBOs do more population-based interventions, such as media campaigns and HIV hotlines.

As displayed in Figure 5 *(Appendix A, page 45)*, the largest percentage of sampled CBOs served more than 2000 people in 1996 (30.7%), followed by 100-499 people (12.7%). The smallest percent served 500-599 and 600-999 (each 5.1%).

Those CBOs that serve fewer people tend to have been providing HIV prevention for less time, and those that serve more people tend to have been providing HIV prevention for more time. Further, those that serve remote and rural areas tend to serve fewer people than those serving inner-city or urban areas.

The CBOs targeting African-Americans were more likely to serve over 2000 people (48% versus 33.5% for the overall sample). This observation could be related to the fact that CBOs targeting African-Americans tend to be in the inner cities and CBOs working in the inner city tend to serve more people.

Sampled CBOs targeting Asian/Pacific Islander populations tended to serve between 600-999 or 1000-1499 people (12% and 22.9% compared to the overall sample's 5.6% and 14%, respectively). Also, those CBOs targeting Native American populations tend to serve fewer people than CBOs in the overall sample. Of the CBOs targeting Native Americans, 44% served less than 100 people in 1996 (14.5% in the overall sample) and 30% served 100-499 (21.1% in the overall sample). This observation may be confounded by the finding that CBOs working in rural areas tend to serve fewer people.

Of the CBOs sampled, 65% had more than half of their board made up of minority members (*see Figure 6, Appendix A, page 46*). Those with less than half minority membership are not just the CBOs targeting Caucasians, but are fairly evenly distributed through the racial/ethnic categories. Asian/Pacific Islander and Alaskan Native organizations are the exception, with a greater tendency to be targeted by CBOs with 75-100% minority board make-up (70% and 75%, respectively, compared to between 41-54% for other racial/ethnic groups).

Program Activities Provided

The CBOs were asked to select all the program activities they carried out in 1996 from a list (*see Figure 7, Appendix A, page 47*). The five most frequently selected program activities include service referrals, risk-reduction counseling, peer-based community interventions, street/bar outreach, and media public information campaign. The two least common, both of which had significantly lower frequencies from the other choices, are needle exchange and partner elicitation/notification.

The sampled CBOs were also asked to select the three activities they consider to be their primary services. Of the primary services selected, the top five are street/bar outreach, risk-reduction counseling, peer-based community interventions, HIV antibody testing, and service referrals. The least commonly selected are partner elicitation/notification, community needs assessment, client transportation, needle exchange, and HIV/AIDS hotline.

There were two categories for adding additional services provided: "other" and "technical assistance." The most frequently mentioned types of technical assistance provided are cultural competency or cultural sensitivity; program development; and assistance with other services including housing, welfare, finances, meals, clothing; and training. The most commonly noted categories under "other" were education (health, prevention), clinical services, mental health services, and support services.

Groups Served

The five groups most commonly served by the sampled CBOs are community-at-large, gay-identified men who have sex with men (MSM), injecting drug users, youth in general, and heterosexual women (*see Figure 8, Appendix A, page 48)*. The five groups served by the smallest number of CBOs are children, incarcerated youth, transgendered individuals, rural/migrant populations, and immigrants.

These most and least served groups remained constant in answer to the question, "Which three represent your primary target group?", with the exception that incarcerated adults and same-sex youth replaced rural/migrant populations and immigrants in the lowest five. This is possibly due to the fact that, though there are few organizations serving these two groups (rural/migrant populations and immigrants), those that do specifically target them.

It is important to determine whether those groups receiving service from few CBOs are getting prevention services through other means. If this is not the case, strategies should be developed to ensure that all groups are accessing important prevention services.

Asian and Pacific Islander American Health Forum

The Asian and Pacific Islander American Health Forum (APIAHF) assessed the technical assistance and training (TA/T) needs of community-based organizations (CBOs) targeting Asians and Pacific Islanders. APIAHF's assessment also focused on the cultural and linguistic diversity among Asians and Pacific Islanders, as well as on the Asian and Pacific Islander populations at highest risk for HIV infection, including Asian and Pacific Islander gay and bisexual men and other men who have sex with men (MSM) and Asian and Pacific Islander youth.

APIAHF's assessment used multiple methodologies during August 1997 through August 1998. The methodologies included two surveys of 80 CBOs that target Asians and Pacific Islanders (with a total of 57 responding CBOs from 15 states; Washington, DC; and Guam, for a 71% response rate to one or both surveys); a survey of 30 national, territorial, state, and local health departments and Health Ministries in jurisdictions with the highest numbers of Asian and Pacific Islander residents (with 24 responses for an 80% response rate); five regional focus groups with staff of HIV prevention programs targeting Asian and Pacific Islander gay and bisexual men (with 36 participants from 17 CBOs); eight local focus groups of Asian and Pacific Islander youth (with 80 participants under age 25 from six cities); and six key informant interviews with leaders of Asian and Pacific Islander gay groups from six cities.

HIV Prevention Programs for Asians and Pacific Islanders

About half of the HIV prevention programs targeting Asians and Pacific Islanders are in California and Hawaii, and the majority are based in urban areas. The TA/T needs of CBOs where programs are geographically concentrated are different than those of CBOs where there may be less community, financial, political, and social support for HIV prevention interventions for Asians and Pacific Islanders. Even in states with large numbers of Asian and Pacific Islander residents there were significant gaps in the availability of HIV testing in Asian and Pacific Islander languages, information and materials in Asian and Pacific Islander languages, and funding for Asian and Pacific Islander HIV prevention programs.

The unique TA/T needs of the six U.S.-affiliated Pacific jurisdictions must be included in the provision of TA/T to Asians and Pacific Islanders. Although there are few CBOs (or non-governmental organizations) engaged in HIV prevention in the Pacific jurisdictions, culturally appropriate TA/T to the Health Ministries and health departments in the Pacific jurisdictions is critical to the success of HIV prevention efforts in the region.

Organizational Development Needs

Asian and Pacific Islander CBOs need TA/T on a diverse number of organizational development issues, especially fund raising and resource development, strategic and long-term planning, volunteer program development, and collaboration.

HIV/AIDS Surveillance and Epidemiology

Asian and Pacific Islander CBOs need TA/T on obtaining information about the HIV prevention needs of Asians and Pacific Islanders, especially among specific ethnicities/national origin populations. The majority of the responding CBOs use available surveillance data. However, the inadequacy of data disaggregated by Asian and Pacific Islander ethnicities/national origins means that CBOs seeking to target Asians and Pacific Islanders must utilize other sources of data to document the HIV prevention needs of Asian and Pacific Islander communities. CBOs could use TA/T in conducting their own community needs assessments to provide additional information to health departments, HIV prevention CPGs, and funders about the HIV prevention needs of Asians and Pacific Islanders.

HIV Prevention Community Planning

Asian and Pacific Islander CBOs need TA/T on increasing participation and effectiveness within HIV prevention community planning. Given their under-representation on most HIV prevention CPGs, Asian and Pacific Islander members often face difficulties ensuring that the needs of Asians and Pacific Islanders are included in the planning process and the establishment of HIV prevention priorities. TA/T on parity, inclusion, and representation for Asians and Pacific Islanders within community planning is a high priority.

Program Development and Program Evaluation

Asian and Pacific Islander CBOs need TA/T on:

- developing and evaluating culturally appropriate HIV prevention interventions targeting Asians and Pacific Islanders at the highest risk for HIV infection. The majority of the responding CBOs target specific HIV risk behaviors, often focusing on MSM and youth. Other programs focus on Asian and Pacific Islander women, transgendered persons, and commercial sex workers.

- developing and evaluating culturally and linguistically appropriate HIV prevention interventions targeting specific ethnicities/national origin populations. HIV prevention interventions must be tailored for specific ethnicities/national origin populations in order to be effective. Given the inadequacy of HIV prevention materials in Asian and Pacific Islander languages, national coordination of the development and dissemination of Asian and Pacific Islander-language HIV prevention materials is critical.

- developing organizational capability, leadership, and community-level HIV prevention interventions to build community capacity and impact community norms in support of effective HIV prevention interventions. Among Asians and Pacific Islanders, gay and bisexual men and other MSM remain the most impacted behavioral risk population for HIV infection, with 74% of the cumulative Asian and Pacific Islander male AIDS cases reported among MSM. Continued TA/T that builds organizational and individual capacities among Asian and Pacific Islander gay and bisexual men is vital.

- developing culturally and linguistically appropriate group and community-level HIV prevention interventions. Most Asian and Pacific Islander CBOs conduct individual-level interventions. Coordinated multiple-level interventions may be more effective.

- improving the evaluation of their HIV prevention programs, especially outcome evaluation. Although almost all Asian and Pacific Islander CBOs evaluate their programs, most use only process evaluation measurements. Few use outcome and impact evaluation in their programs.

Behavioral and Social Science

Further development, evaluation, validation, and diffusion of culturally appropriate HIV prevention interventions for Asian and Pacific Islander populations, especially targeting those at highest risk for HIV infection, is needed. There has been almost no prevention science research or evaluation of HIV prevention programs for Asians and Pacific Islanders. Coordinated efforts to identify or develop and then evaluate interventions that are culturally and linguistically appropriate for each Asian and Pacific Islander ethnicity/national origin population and each risk behavior group population are needed.

Asian and Pacific Islander CBOs also need TA/T to address the co-factors for HIV risk and the facilitators to HIV risk reduction that are most common among Asians and Pacific Islanders. This may require the development of TA/T on issues of culture, identity, and other structural issues not currently part of TA/T on HIV prevention. Asian and Pacific Islander CBOs continue to need opportunities to build collaborative relationships with researchers to jointly strengthen HIV prevention programs through the application of HIV prevention science.

Collaboration/Cooperation

Staff from Asian and Pacific Islander CBOs continue to need opportunities to network; share lessons learned, experiences, and expertise; and support one another. National, regional, and local conferences, working groups, and other opportunities to convene are important TA/T activities for Asians and Pacific Islanders. More formal mentorship, leadership development, and staff exchange programs also should be developed to build staff capacities.

Asian and Pacific Islander CBOs also continue to need opportunities to network, etc., within specific ethnicities/national origin populations. Such opportunities can improve the cultural competence and linguistic accessibility of programs for Asians and Pacific Islanders.

Asian and Pacific Islander CBOs need TA/T in exploring new models of collaboration and delivery of HIV prevention programs for Asians and Pacific Islanders. In an increasingly competitive funding environment, Asian and Pacific Islander HIV prevention programs will be challenged to explore and implement innovative collaborations with other Asian and Pacific Islander community institutions, other HIV prevention programs (especially in other communities of color), health departments, and funders to sustain their efforts in the future.

Technical Assistance and Training Providers and Formats

Asian and Pacific Islander CBOs need TA/T from diverse providers, including the CDC, state and local health departments, NRMOs, other CBOs, and academic institutions. Each of these TA/T providers must provide TA/T appropriate to their particular knowledge, expertise, and TA/T skills. For example, it makes most sense for NRMOs to continue to focus their TA/T efforts on the unique cultural and linguistic barriers and facilitators to effective HIV prevention interventions within communities of color, such as within the Asian and Pacific Islander communities. NRMOs also should continue to build and strengthen national, regional, and local collaborations and increase coordination among Asian and Pacific Islander CBOs. TA/T should continue to be made available in a diverse number of TA/T delivery methods, including conferences, training workshops, site visits, written information, and phone and e-mail contact.

Inter-Tribal Council of Arizona

There are many health challenges facing the American Indian/Alaska Native/Native Hawaiian (AI/AN/NH) populations nationwide. HIV prevention is one of the challenges. This report is the result of the first national attempt to assess the technical assistance and training needs of HIV prevention programs serving AI/AN/NH populations in the contiguous 48 states, Alaska, and Hawaii. It represents the efforts of the many individuals in the AI/ANA/NH rural, remote, and urban populations who are working diligently to provide HIV/AIDS prevention education and care for their respective communities. It also provides documentation for the individuals who work in this field to use for planning, implementing, and evaluating HIV prevention programs and activities.

This study was a collaborative effort between the Inter-Tribal Council of Arizona, Inc., Northwest Portland Area Indian Health Board, and National Native American AIDS Prevention Center. A combination of seven different surveys was used to collect quantitative data, and eight focus groups/talking circles were conducted to collect qualitative data.

Epidemiology and Surveillance

Findings

- Most Tribal Leaders Survey respondents and Tribal Health Directors Survey respondents did not think that members of their communities view HIV/AIDS as a problem. Native people do not feel they are at risk or associate HIV/AIDS with risk behaviors. Tribal Health Director and Tribal Leader Survey respondents ranked some of the risk factors associated with HIV/AIDS (e.g., alcoholism) high on the priority list, yet did not rank HIV/AIDS prevention as a priority.

- Despite the availability of HIV testing, native people tend not to get tested. Confidentiality was cited most often as a barrier to testing. Native communities tend to be tight-knit, and health providers may know or be related to persons seeking testing. Focus group participants reported that native people fear even asking for information about HIV/AIDS because other community members will assume they must be infected.

- The majority of state health department respondents indicated they do not collect HIV/AIDS statistics from the Indian Health Service (IHS). The majority of IHS service units reported that they did not collect HIV/AIDS statistics from AI/AN tribes/villages/governments or share HIV/AIDS statistics with AI/AN/NH governments/organizations or the state HIV CPGs. The majority of tribal health department respondents indicated they are not reporting HIV/AIDS cases to any agencies/organizations that collect epidemiologic/surveillance information. This is likely to influence AI/AN/NH communities' awareness of HIV/AIDS as a health issue and how AI/AN/NH prevention needs are perceived by other federal and state agencies.

- Possible reasons epidemiologic/surveillance information is generally not being used by the AI/AN/NH HIV prevention programs include, but are not limited to 1) testing barriers, 2) racial/ethnic misclassification, 3) migration issues, and 4) surveillance reports that do not include relevant or accurate information about native people.

- AI/AN/NH AIDS cases may not appear statistically significant in state and CDC surveillance reports because some states, even those with significant AI populations, do not have AI/AN/NH race/ethnicity categories on their HIV testing forms. In every focus group, race/ethnicity misclassification was reported to be a problem. Other causes of misclassification include testing counselors marking race/ethnicity according to surname or appearance rather than asking the person being tested, and some native people not self-identifying as being natives when seeking HIV testing. These misclassification problems also appear on death certificates.

- Survey data from this study confirm that migration between urban and rural areas is a common practice among AI/AN/NH. Urban Program Survey respondents reported serving rural clients in addition to urban clients. Substance Abuse Program Survey respondents also indicated that a significant portion of their service population migrates between urban and rural/remote/ reservation communities.

- Focus group participants also indicated an urgent need for tribal-specific surveillance information, including data collection and management, to help raise HIV/AIDS awareness and support for HIV prevention activities in their communities.

Recommendations

- Surveillance reporting systems must be coordinated between IHS, tribal governments/health consortia, state health departments, and the CDC to ensure accurate reporting.

- HIV testing and reporting forms should be standardized to include race/ethnicity categories for AI/AN/NH. The training for HIV testing counselors must include how to appropriately and accurately obtain the race/ethnicity of individuals seeking testing.

- CDC should collaborate with tribal and state governments and the IHS to develop a coordinated HIV/AIDS surveillance system able to protect the confidentiality of tribal members, but provide tribal governments with tribal-specific surveillance rates.

- IHS should revise/develop HIV/AIDS protocols to ensure confidentiality of persons seeking HIV testing in small, tight-knit native communities where IHS employees are related to or know persons seeking testing services.

- AI/AN/NH health programs need to coordinate their efforts, to understand how the various diseases they are working to prevent impact each other, and to understand how coordinated efforts can provide benefits for all.

- Surveillance reports should be made more user friendly and easier for lay people to use.

- High rates of risk factors for HIV/AIDS infection should be included in surveillance reports of populations even if reported HIV/AIDS case rates are not available. This will provide an indication of the potential risk for a population to become infected and help communities, tribes, states, and federal agencies to prioritize appropriately.

- The CDC should coordinate surveillance systems with the governments of Canada and Mexico.

HIV Prevention Community Planning

Findings

- The majority of HIV Prevention Provider and Tribal Health Director respondents reported that they are not involved in their respective state HIV prevention CPG. The majority of Urban Program respondents indicated they had knowledge about the Statewide HIV prevention Community Planning Group (CPG) Plan, but did not use it in prevention efforts or in program or policy development. According to 62.1% of the Tribal Health Director respondents, tribal health department staff participate on a variety of health-related community planning groups other than HIV prevention. Other planning groups include diabetes, heart disease, and substance abuse.

Recommendations

- State CPGs should invite tribal leaders to appoint appropriate tribal representatives to participate in the CPG process.

- The CDC must support the incorporation of ethnic/racial subcommittees into each state's CPG and the formation of AI/AN/NH Regional HIV Prevention CPGs.

- CPGs should regularly mail the CPG plan, meeting minutes, and other pertinent CPG information to appropriate tribal departments and representatives.

- The Native NRMOs must offer "HIV Community Planning 101" sessions to tribes and urban programs within their respective service areas.

- The CDC must include all tribes, Native Hawaiian groups, and Alaskan Consortia on their mailing lists for HIV Prevention information distribution and funds availability.

Organizational Development

Findings

- While Native HIV prevention providers are providing prevention services, the capacity of most programs is limited due to lack of funding. A large number of Urban Program and HIV Prevention Provider respondents said they provide other services related and unrelated to HIV. More than 41% of 150 total HIV Prevention Provider, Urban Program, and Tribal Health Department respondents reported they are providing HIV prevention services on a scarce-to-zero budget.

- The top three organizational development TA/T needs reported by Urban Program and HIV Prevention Provider respondents are 1) Fund Raising, 2) Grant Writing, and 3) Training in HIV Education/Prevention Services.

- The top four staff development TA/T needs for Prevention Providers are 1) current HIV/AIDS information regarding medical and behavioral treatments; 2) training in gay, bisexual, lesbian, transgender, and two-spirit programming; 3) assistance in accessing traditional healing; and 4) training in women's health.

- The top four staff development TA/T needs for Urban Programs are 1) current HIV/AIDS information regarding medical and behavioral treatments; 2) training in women's health; 3) training in advocacy; and 4) training in gay, bisexual, lesbian, transgender, and two-spirit programming.

Recommendations

- The language in funding announcements written by federal agencies must include tribes, Native Alaskan Consortia, and Native Hawaiian Consortia as eligible recipients of funds.

- The Native NRMOs must continue to provide technical assistance, skills-building workshops, capacity development, and dissemination of HIV prevention information.

- More funding must be allocated to the NRMO Program to permit the funding of additional Native NRMOs in order to better serve the AI/AN/NH populations. Special consideration needs to be given to Alaska and Hawaii due to their geographic isolation.

Collaboration

Findings

- Collaboration and coordination of services are common practices among HIV prevention programs in urban and rural areas. However, collaboration between substance abuse programs and HIV prevention programs is minimal.

- Focus group participants expressed the need to have more opportunities to network with other Native HIV prevention providers locally, regionally, and nationally.

- The top five barriers reported to collaborating are 1) turf/territorial issues; 2) lack of funding; 3) other organizations' lack of knowledge and/or awareness of HIV prevention and AI/AN/NH culture; 4) competition for funding; and 5) lack of community support.

- The top five identified gaps in services reported by Urban Program and Prevention Provider respondents are 1) traditional healing/spiritual services; 2) housing, food, and emergency services; 3) mental/behavioral health services; 4) substance abuse treatment services; and 5) support group services.

Recommendations

- The CDC and Substance Abuse and Mental Health Survey Administration must collaborate to make funding available to AI/AN/NH populations to properly address HIV and substance abuse.

- The Native NRMOs must develop a working relationship between HIV prevention programs and substance abuse programs serving AI/AN/NH communities.

- The Native NRMOs must provide the opportunity for urban, rural, and tribal communities to network and collaborate by establishing a national network of HIV prevention providers.

Evaluation

Findings

- Evaluation is not fully understood or practiced by prevention providers and urban programs, even though the majority of respondents who answered questions about evaluation reported having their HIV prevention programs for at least 7-10 years. A significant number of HIV Prevention Provider respondents indicated that their organization did not evaluate its HIV program. For those respondents who reported using evaluation, the most common type used is pre/post tests. Impact and outcome evaluation methods are not readily used.

- The top three evaluation TA/T needs reported by Urban and Prevention Provider respondents are 1) basic evaluation methods, 2) translating evaluation findings into program improvements, and 3) identifying training opportunities for staff.

Recommendations

- Native NRMOs must offer more individualized training to HIV prevention programs serving the AI/AN/NH communities on how to evaluate their programs in order to plan appropriate services and improve programs.

- Basic skills-building workshops on topics such as evaluation, implementation, proposal writing, and presentation development must continue to be offered by the Native NRMOs to the AI/AN/NH communities and should be included on national conference agendas.

- Tailored assessments of individual AI/AN/NH communities must occur to provide baseline data from which communities can build in terms of behavior change and interventions that worked/ did not work.

Behavioral and Social Science

Findings

- Social Science/Behavioral Research was the second most indicated area of TA/T need.

- AI/AN/NH providers, except for substance abuse programs and state health departments, indicated that TA/T in working with specific populations, such as youth and MSM, is their primary social science/behavioral research need.

- Ninety-five percent of state health departments indicated a need for TA/T in working with AI/AN/NH people and governments.

Recommendations

- Cultural competency training should be mandatory for state and federal agency personnel working with native people. The training should include education about diversity among native people and the infrastructure through which services are delivered.

- TA/T in interpreting social science/behavioral research should be provided to existing HIV prevention programs in order to increase understanding of strategies used to work with particular populations and to achieve social and behavioral objectives.

- More native-specific social science/behavioral research on HIV prevention models needs to be developed and recognized as valid and appropriate for use with native people. Social science and behavioral research TA/T should be culturally competent, incorporating models that have been proven successful for native people.

- Since most native providers serve the community at large, social science and behavioral research TA/T that will facilitate improved outreach and service to the whole community should be considered as an approach by NRMOs. TA/T providers should assess the specific skill levels of individual prevention providers and develop training accordingly.

Biomedical Research

Findings

- Less than one-third of HIV prevention providers and urban programs are using biomedical research in prevention counseling or program/policy development, except in the area of HIV transmission. TA/T in biomedical research was not indicated as a primary need for any of the providers surveyed. However, HIV prevention providers and urban programs (direct service providers) indicated that TA/T in the biomedical research areas of HIV testing, HIV/AIDS treatment, and HIV transmission would be useful.

- Tribal Health Directors indicated a greater need for TA/T HIV/AIDS treatment than any other biomedical research area. Over half of substance abuse programs indicated a need for TA/T in the medical consequences of substance abuse and HIV/AIDS treatment. Tribal Health Directors' and other providers' need for TA/T in treatment suggests that some providers may be seeing cases of HIV/AIDS in their communities.

Recommendations

- TA/T providers should assess the specific biomedical research needs of individual prevention providers and develop training accordingly. Needs for TA/T in biomedical research should be weighed against the need for other types of TA/T, to ensure that prevention providers will be able to use the TA/T. For example, TA/T on different methods of testing may not be useful if the provider does not provide testing services.

- The Native NRMOs must regularly provide relevant HIV/AIDS research information to prevention providers and tribal health directors. A national AI/AN/NH HIV/AIDS clearinghouse center for information relevant to HIV/AIDS should be established by the native NRMOs.

Conclusion

This assessment highlights the many needs of HIV/AIDS prevention programs in AI/AN/NH communities. Effective prevention requires accurate surveillance, including proper documentation of the pattern, distribution, severity, and spread of HIV. Findings from this study indicate that accurate surveillance is not occurring now. Additionally, effective HIV prevention requires evaluation of existing programs and prevention strategies, as well as easily accessible outreach programs. All of these functions require full collaboration between federal, state, tribal, and municipal authorities to ensure that AI/AN/NH communities/governments receive the HIV prevention expertise, training, and technical assistance they need. Public health entities should provide technical assistance and training in a manner that is inclusive and culturally appropriate. It is also important that AI/AN/NH community health programs have direct access to federal and state financial resources for HIV prevention.

National Alumni AIDS Prevention Project

For both the survey and focus group research conducted by the Jackson State University National Alumni AIDS Prevention Project (NAAPP), the target population was defined as community-based organizations (CBOs) that provide HIV prevention services to communities of color, with special emphasis on African-American and other minority-based agencies. The survey was mailed to a randomly selected sample of the target population in twenty-five (25) states: Alabama, Arizona, Arkansas, California, Delaware, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, New Jersey, Ohio, Rhode Island, South Carolina, Tennessee, Texas, Washington, and Wisconsin. (By prior arrangement, NMAC was responsible for surveying CBOs serving communities of color in the other states.) One hundred fourteen (114) surveys were returned for a response rate of 26.4%. Over a quarter (28.1%) of the survey respondents were African-American CBOs and 14% were other minority-based agencies. Over 40 minority-based agencies participated in four focus groups held in Maryland and Virginia.

TA/T most needed by Minority CBOs included effective fundraising strategies for organizational development, information exchange and referral for collaboration, obtaining relevant and appropriate behavioral science research, and translation of evaluation findings for programs. Diversity and cultural competence issues were also seen as primary TA/T needs for HIV prevention community planning and other collaborative efforts. In both the surveys and focus groups, Minority CBOs indicated a strong desire for training on the design and use of theory-driven interventions. Finally, lack of funding was seen as the key to a number of programmatic and organizational issues. Key technical assistance needs regarding funding included finding resources for collaborative projects, effective fundraising strategies, and grantwriting.

Based on the results of this assessment, the following recommendations are offered:

- Increase the number and amount of funding opportunities for minority organizations who provide HIV prevention services to their communities.
- Identify, develop, disseminate, and support culturally competent behavioral science research.
- Provide more on-site and one-on-one technical assistance on behavioral science and evaluation.
- Recognize and support the process of collaboration—including issues of diversity and cultural competence.
- Aggressively market technical assistance and training services to all HIV prevention programs run by minority CBOs—not just CDC-funded organizations.